COMMUNITY CARE LICENSING DIVISION

"Promoting Healthy, Safe and Supportive Community Care"

TECHNICAL SUPPORT PROGRAM

ADULT RESIDENTIAL FACILITY PREADMISSION QUESTIONNAIRE

CDSS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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PREADMISSION QUESTIONNAIRE

The following questionnaire is designed to assist Adult Residential Facility staff to identify specific issues that may affect the placement of and/or services to be provided to prospective clients of Adult Residential Facilities. The questions on this list should be reviewed with the applicant's responsible party prior to admission to the facility. If the answer to any of the questions on this list is yes, then the intake staff should gather additional information to determine whether or not the facility will be able to admit the applicant and meet his/her needs.

The information on this form supplements the Needs and Services Plan form (LIC 625), but does not replace it. While the information gathered from this form should assist staff in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date: _____

Applicant's Name: _____

Current Residence: _____

Reason for Placement: _____

_____

_____

_____

Applicant's primary physician's name: _____

Applicant's primary physician's phone number: _____

Applicant's case manager's name: _____

Applicant's case manager's phone number: _____

A. MENTAL/DEVELOPMENTAL STATUS

Does the applicant have any of the following diagnoses?

YES **NO**

1. Mental disorder
2. Developmental disability
3. Dual Diagnoses (Mental Health or Regional Center)

If the answer to any of the questions in Section A is yes, please explain the condition:

_____

_____

_____

_____

_____

_____

MENTAL/DEVELOPMENTAL STATUS (Continued)

The severity of the disorder or disability: _____

_____

_____

_____

_____

_____

Any current or previous treatment: _____

_____

_____

_____

_____

_____

B. HEALTH STATUS

YES **NO**

Does the applicant use any prescription or non-prescription medications?
If yes, please list them:

Medication Name	Strength	Dose	Times

HEALTH STATUS (Continued)

Does the applicant have any of the following?

YES **NO**

1. Asthma
2. Epilepsy
3. Allergies
4. Diabetes
5. Eating disorders
6. Visual impairment
7. Physical impairment
8. Infectious disease
9. Special diet
10. Pregnancy
11. Chronic medical condition
12. Incontinence

If the answer to any of the above is yes, please describe:

The type and severity of the condition: _____

_____

_____

_____

_____

The treatment the applicant is receiving for the condition: _____

_____

_____

_____

_____

Any medical apparatus the applicant needs as a result of the condition: _____

_____

_____

_____

_____

Any limitations due to the condition: _____

_____

_____

_____

_____

Any special services required due to the condition: _____

_____

_____

_____

_____

C. RESTRICTED HEALTH CONDITIONS ASSESSMENT

YES **NO**

1. Does the applicant use inhalation-assistive devices? If yes, explain.

_____
_____
_____
_____(See 80092.3)

2. Does the applicant have a colostomy/ileostomy? If yes, explain.

_____
_____
_____
_____(See 80092.4)

3. Does the applicant need enemas, suppositories or fecal impaction removal? If yes, explain.

_____
_____
_____
_____
_____(See 80092.5)

4. Does the applicant use a catheter? If yes, explain.

_____
_____
_____
_____
_____(See 80092.6)

5. Does the applicant have staph or any other serious, communicable infections? If yes, explain.

_____
_____
_____
_____
_____(See 80092.7)

6. Does the applicant have insulin dependent diabetes? If yes, explain.

_____
_____
_____
_____
_____(See 80092.8)

7. Does the applicant have any wounds (e.g., surgical wounds, stage 1 or 2 dermal ulcers, etc.)? If yes, explain.

_____
_____
_____
_____
_____(See 80092.9)

RESTRICTED HEALTH CONDITIONS ASSESSMENT (Continued)

YES **NO**

8. Does the applicant have a gastrostomy? If yes, explain.

_____
_____
_____
_____(See 80092.10)

9. Does the applicant have a tracheostomy? If yes, explain.

_____
_____
_____
_____(See 80092.11)

D. CONDITIONS OF LIFE ASSESSMENT

YES **NO**

1. Does the applicant use oxygen (tank, concentrator or liquid)? If yes, explain. _____
_____
_____
_____
_____
_____(See 80075(h))

2. Does the applicant rely on others to perform all activities of daily living (Eating, bathing dressing, transferring, toileting and continence)? If yes, explain. _____
_____
_____
_____
_____
_____(See 80077.2)

3. Does the applicant have incontinence? If yes, explain.

_____
_____
_____
_____
_____(See 80077.4)

4. Does the applicant have contractures? If yes, explain.

_____
_____
_____
_____
_____(See 80077.5)

E. PROHIBITED HEALTH CONDITIONS ASSESSMENT

YES **NO**

1. Does the applicant use naso-gastric or naso-duodenal tubes? If yes, not allowed in an ARF.

1. Does the applicant have active, communicable TB? If yes, not allowed in an ARF.

3. Does the applicant have conditions requiring skilled nursing care? If yes, not allowed in an ARF.

4. Does the applicant have stage 3 or 4 dermal ulcers? If yes, not allowed in an ARF.

F. FUNCTIONAL STATUS

Do any of the following conditions apply to the applicant?

YES **NO**

1. Non-ambulatory
2. Bedridden/bedfast
3. Paralysis
4. Inability to transfer to and from bed
5. Needs assistance with eating
6. Needs assistance with dressing
7. Needs assistance with bathing
8. Needs assistance with toileting

If the answer to any of the above is yes, please describe:

The type of limitation and its severity: _____

Any assistive devices used by the applicant: _____

Any treatment or therapy needed by the applicant as a result of the condition: _____

G. BEHAVIORS

YES **NO**

Is the applicant a registered sex offender? (Information required per H & S 1522.01) If yes, provide information on offense(s):

_____
_____
_____
_____

Does the applicant have a history of any of the following?

YES **NO**

1. Physical assaultiveness
2. Verbal assaultiveness
3. Sexual assaultiveness or molestation
4. Violence to self or others
5. Cruelty to others
6. Attempts to poison others
7. Use of weapons
8. Cruelty to animals
9. Destruction of property
10. Stealing
11. Arson

If the answer to any of the above is yes, please describe:

The behaviors: _____
_____
_____
_____
_____

The frequency and duration of the behaviors: _____
_____
_____
_____
_____

The approximate date of the last occurrence of the behaviors: _____
_____
_____
_____

Anything that seems to trigger the behavior: _____
_____
_____
_____
_____

Strategies to deal with the behavior: _____
_____
_____
_____
_____

BEHAVIORS (Continued)

Does the applicant have a history of any of the following?

YES **NO**

1. Depression or withdrawal
2. Anxiety
3. Mood swings
4. Suicidal ideation
5. Suicide attempts
6. Paranoia
7. Hallucinations
8. Restlessness or hyperactivity
9. Inappropriate sexual activity
10. Confusion with sexual identity
11. Non-compliance
12. Refusal to attend therapy

If the answer to any of the above is yes, please describe:

The behaviors: _____

The frequency and duration of the behaviors: _____

The approximate date of the last occurrence of the behaviors: _____

Anything that seems to trigger the behavior: _____

Strategies to deal with the behavior: _____

BEHAVIORS (Continued)

Does the applicant have a history of any of the following?

YES **NO**

1. Disruptiveness
2. Tantrums
3. Wandering
4. AWOL
5. Substance abuse
6. Ingestion of toxic substances
7. Refusal of medications
8. Refusal of medical treatment
9. Refusal to bathe or wear clean clothes
10. Resistance to authority
11. Careless disposal of smoking materials

If the answer to any of the above is yes, please describe:

The behaviors: _____

The frequency and duration of the behaviors: _____

The approximate date of the last occurrence of the behaviors: _____

Anything that seems to trigger the behavior: _____

Strategies to deal with the behavior: _____

Applicant/Responsible Party: _____

Date: _____

Facility Representative: _____

Date: _____